No. 80-802

IN THE

Supreme Court of the United States

October Term, 1980

NATIONAL GERIMEDICAL HOSPITAL AND GERONTOLOGY CENTER,

Petitioner,

v.

BLUE CROSS OF KANSAS CITY AND BLUE CROSS ASSOCIATION,

Respondents.

On Petition For A Writ of Certiorari To The United States Court of Appeals For The Eighth Circuit

BRIEF OF RESPONDENT BLUE CROSS ASSOCIATION IN OPPOSITION TO THE PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

The National Health Planning and Resources Development Act of 1974 directs federally-designated regional Health Systems Agencies, with the assistance of private parties, to restrain unneeded construction of hospital facilities.

In this case, a hospital which was constructed in disregard of a determination by a Health Systems Agency that additional hospital beds were unwarranted in its area, applied to the local Blue Cross Plan for a reimbursement contract. The Blue Cross Plan adhered to its policy of contracting only with hospitals for which there was a community health need.

The question presented is whether the Health Planning Act of 1974 partially repeals the antitrust laws by implication in the specific situation where a Blue Cross Plan follows a determination made by a Health Systems Agency against new hospital construction.

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BRIEF OF RESPONDENT BLUE CROSS ASSOCIATION IN OPPOSITION TO THE PETITION FOR A WRIT OF CERTIORARI

This brief is submitted on behalf of respondent Blue Cross Association in opposition to the petition for a writ of certiorari. The Blue Cross Association concurs in petitioner's statements under the headings *Opinions Below* and *Jurisdiction.*

STATUTORY PROVISIONS INVOLVED

The statutes involved in this case are set forth in the Appendix at the end of this brief. These include Sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1, 2, and certain provisions of the National Health Planning and Resources Development Act of 1974, 42 U.S.C. §§ 300k *et seq.* The 1974 Act, which is involved in this case, was extensively amended in 1979. Pub. L. No. 96-79, 93 Stat. 593.

STATEMENT OF THE CASE

"Overbedding" is the term used to describe the construction of excess hospital facilities in a region, creating needless inflation in the cost of health care. While the cost of all health care has risen at an alarming rate in recent years, one of the most serious problems involves "inpatient" services, *i.e.*, hospital stays. To combat this, Congress enacted the National Health Planning and Resources Development Act of 1974, 42 U.S.C. §§ 300k *et seq.* (the "Health Planning Act of 1974") to develop "a national health planning policy" and to facilitate regional and state planning. 42 U.S.C. §§ 300k(a)(4); 300k(b).

The key elements under this legislation are the regional Health Systems Agencies ("HSA's"), which are charged with comprehensive regional health planning. Each HSA includes a professional staff and a governing body, the majority of which must be composed of consumers of health care and the remainder of "providers," which are defined to include third-party payers such as Blue Cross Plans. 42 U.S.C. § 300*l*-1 (b)(3)(C)(ii).

The duties of the HSA under the Act include "restraining increases in the cost of providing . . . health services" and "preventing unnecessary duplication of health resources." 42 U.S.C. § 300*l*-2(a)(3),(4). Each HSA has "as its primary responsibility the provision of effective health planning for its health service area." 42 U.S.C. § 300*l*-2(a)(5). This includes the reduction of documented inefficiencies and the formation of long-term Health Systems Plans ("HSP's"), which must be implemented *"with the assistance of individuals and public and private entities."* 42 U.S.C. § 300*l*-2(c)(1) (emphasis added).

In 1976 the United States Department of Health, Education and Welfare (now Health and Human Services) designated Mid-America Health System, Inc. ("MAHSA") as the HSA for the eight-county bi-state region comprising the metropolitan Kansas City area. (App. 4a).[1] MAHSA is a not-

[1] As noted by the Court of Appeals (App. 4a), MAHSA was notified of its conditional designation by HEW by letter of April 7,

for-profit "quasi-public" corporation,[2] whose sole purpose is to provide health care planning for the Kansas City area. Pursuant to its statutory responsibilities, MAHSA developed a long-range Health Systems Plan, "HSP 1978-1982," which was formally adopted as the five-year Health Systems Plan for the region in 1977. (HSP Foreword).

In the Plan, MAHSA identified, as one of its main objectives, the need to find a solution to the growing surplus of hospital beds in the Kansas City area. (HSP at 6-19 and 8-1). It found that the acute inpatient care system was already meeting the needs of the population (*id.* at 7-3) and that by 1983 the region would have as many as 2,420 surplus hospital beds. (*Id.* at 5-68 and 7-3). The area already had five staffed hospital beds for each 1,000 population (*id.* at Appendix F, Table 9), and if all beds then planned or under construction had been built, the figure would have risen to 6.3 beds per 1,000. (*Id.* at Appendix F, Table 9). HEW guidelines recommend fewer than four beds per 1,000. National Guidelines for Health Planning, § 121.201, 43 Fed. Reg. 13045 (1978). Unused hospital beds cost a community one-third of their initial cost incrementally each year, S. Rep. No. 93-1285, 93d Cong., 2d Sess., *reprinted in* [1974] U.S. Code Cong. & Ad. News

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1976. All designations of HSA's were conditional at that time because the program was still relatively new. *See* 42 U.S.C. § 300*l*-4(b); S. Rep. No. 96-96, 96th Cong., 1st Sess. 6, *reprinted in* [1979] U.S. Code Cong. & Ad. News 1306, 1311.

As used herein, "App." refers to the appendices to the petition for certiorari; "Pet." refers to the petition itself; and "BCA Aff." indicates the affidavit which was filed with the district court as Exhibit A to the BCA Suggestions of August 14, 1978.

[2] In the Court of Appeals, the Federation of American Hospitals, as *amicus curiae,* characterized MAHSA as a "quasi-public agency." (Federation of American Hospitals' Brief at 13). The Federation of American Hospitals is an organization representing investor-owned, profitmaking private hospitals (Federation of American Hospitals' Motion for Leave to File Amicus Curiae Brief at 2), which was represented in the Court of Appeals by the lead counsel now representing National Gerimedical before this Court.

7879, and there is a marked tendency for surplus beds to be filled unnecessarily by patients who either do not genuinely need to be hospitalized or who stay longer than is medically warranted. *Id.* at 7878. On the basis of its findings, MAHSA determined that it was unnecessary to add to the number of acute care hospital beds available in the Kansas City area and announced that no additional beds would be approved. (App. 7a).

Disregarding this determination, petitioner National Gerimedical Hospital and Gerontology Center ("National Gerimedical") proceeded to erect a new 120-bed acute care hospital in metropolitan Kansas City. A year before its opening on October 16, 1978, National Gerimedical applied to the local Blue Cross Plan, Blue Cross of Kansas City ("Blue Cross"), for a participating contract which would have enabled National Gerimedical to receive reimbursement directly from Blue Cross. (Pet. at 3). Blue Cross replied that it would adhere to its pre-existing policy of contracting with newly built or expanded hospitals only when their area HSA had determined that the community needed the additional facilities. (App. 5a-7a). On March 21, 1978, Blue Cross informed National Gerimedical that its application had been denied. National Gerimedical proceeded to open seven months later. (Pet. at 3).

The complaint, filed in the United States District Court for the Western District of Missouri, charged Blue Cross and the Blue Cross Association ("BCA") with conspiring with MAHSA and others[3] to refuse to deal with National Gerimedical and thereby to place it at a competitive disadvantage in violation of Sections 1 and 2 of the Sherman Act. The district judge granted summary judgment, dismissing the complaint on the ground that the Health Planning Act of 1974 impliedly repealed the federal antitrust laws. The United States Court of Appeals for the Eighth Circuit affirmed by opinion without dissent. A

[3] MAHSA and the others were identified as non-party co-conspirators. (Complaint ¶¶ 6-12).

rehearing was denied, also without dissent. National Gerimedical then petitioned this Court for a writ of certiorari.

BCA is an Illinois not-for-profit membership corporation to which Blue Cross Plans throughout the United States belong. (BCA Aff., ¶ 2). BCA's functions include statistical and research services for the local Plans. (*Id.* ¶ 3). BCA does not do business in Missouri and does not offer health care plans in Missouri or elsewhere; it does not contract with hospitals. (*Id.* ¶¶ 3, 4, 7). The statement of purpose in BCA's Articles of Incorporation specifies that "inherent in [BCA's] purposes is a recognition that State and local Plans are, and should be, autonomous in their operation and that the needs, facilities, resources and practices of the respective areas shall be given due consideration." (BCA Aff., ¶ 3). Nevertheless, National Gerimedical alleged in its complaint that BCA conspired in formulating the local Blue Cross policy of refusing to contract with unapproved hospitals. (Complaint ¶ 18(a)).

Blue Cross of Kansas City ("Blue Cross") is a not-for-profit community service organization, organized pursuant to Missouri law[4] and subject to the supervision and regulation of the Missouri Director of Insurance. It offers individual and group health care reimbursement plans to the general public in Missouri and Kansas. (Complaint ¶ 4). Blue Cross subscribers account for "approximately one fourth of all area hospital admissions" in the Kansas City region. (Pet. at 4). A majority of Blue Cross' board and its executive committee are representatives of the public, consisting of community, business and labor leaders. (Blue Cross Int. Ans., Exhibit A). Blue Cross is a member of BCA, but BCA has neither the power nor the duty to control Blue Cross' contracts with any hospital. (BCA Aff., ¶ 4; BCA Int. Ans., Exhibits E & F).

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[4] Mo. Rev. Stat. § 354.010 *et seq.*

REASONS FOR DENYING THE WRIT

I. The Decision of the Court of Appeals Does Not Create a Precedent Which Warrants Review by This Court

Although petitioner contends that the decision of the Court of Appeals is of substantial precedential significance and "likely to stimulate many other cases in this area" (Pet. at 10), this case cannot arise again. As the Court of Appeals pointed out (App. 5a), National Gerimedical took advantage of a hiatus in Missouri health planning review of proposed hospital capital expenditures which arose in June 1976, when Missouri refused to renew its contract with HEW under section 1122 of the Social Security Act, 42 U.S.C. § 1320a-1. In August, 1979 (effective October 1, 1980) Missouri enacted certificate of need legislation that bars the construction of new hospitals[5] which have not been approved by a state planning agency, acting under the guidance of an HSA.[6] Mo. Ann. Stat. §§ 197.300 *et seq.* (Vernon Supp. 1980).

On a national scale, every other state has a certificate of need law which precludes construction of unapproved hospitals except Louisiana, where such legislation has been proposed and need review is presently conducted under section 1122 of the Social Security Act.[7] Accordingly, the opportunity to build an

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[5] The application of the decision below is further limited by the fact that every other acute care hospital in the Kansas City area already has a participating contract. (Pet. at 4).

[6] As described by the Court of Appeals (App. 2a-3a), federal legislation requires states to establish need approval requirements for new construction in order to be eligible for federal funding and Medicaid or Medicare repayment programs. 42 U.S.C. §§ 246, 291, 1320a-1. *See also* 42 U.S.C. § 300m-2(a)(4). The Department of Health and Human Services (formerly HEW) is authorized to enter into agreements with participating states, designating a state agency as the health planning authority charged with need review. 42 U.S.C. 1320a-1. The state agency must act in coordination with the recommendations of the regional HSA's, 42 U.S.C. §§ 300*l*-2(f), 300m-2(a)(4)(B), and the certificate of need program must provide for procedures and penalties to enforce its requirements. *Id.*

[7] *See* CHAYET & SONNENREICH, P.C., CERTIFICATE OF NEED: AN EXPANDING REGULATORY CONCEPT, 155-944 (1978).

unnecessary hospital, which existed in this case, was not only a brief one in Missouri, it has now been eliminated in virtually the entire country.[8]

Furthermore, while this case arose under the original Health Planning Act of 1974, the Act was extensively amended in 1979. *See* 93 Stat. 593. Although the 1979 amendments are relevant in illuminating the intent of Congress, this case was decided by the Court of Appeals under the original 1974 Act, not the subsequent 1979 Act.[9]

In an attempt to magnify the significance of the decision below, petitioner asserts that there are two cases currently pending "presenting similar or related questions." (Pet. at 10). In a sector of the economy which, according to petitioner, "accounts for almost one-tenth of the nation's total GNP" (Pet. at 8), two cases hardly constitute a groundswell of litigation. Even this number is an overstatement, however, because each of the two actions involves a variety of issues and may ultimately be decided on grounds which are of no relevance to this case.[10]

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[8] This is not surprising, since enactment of certificate of need legislation is a prerequisite to obtaining federal funds. See note 6 *supra*.

[9] Although petitioner cites to the 1979 amendments, as discussed in Section III.A. *infra*, the Court of Appeals restricted its decision to the original 1974 Act, "Public Law 93-641." (App. 1a).

[10] In Huron Valley Hospital, Inc. v. City of Pontiac, 466 F. Supp. 1301 (E.D. Mich. 1979), *appeal docketed*, No. 79-1265 (6th Cir. May 16, 1979), summary judgment was granted to defendants on three different grounds, only one of which was implied repeal. (Pet. at 27). In North Carolina v. P.I.A. Asheville, Inc., Civ. No. A-C-80-29 (W.D.N.C., filed Feb. 22, 1980), all proceedings have been stayed pending final action by the state on a certificate of need application filed by defendants for transfer of ownership of their hospitals. In addition, only one of the three grounds alleged for dismissal in defendants' motion for judgment on the pleadings involves implied repeal. (Pet. at 27-28).

Moreover, the one decision which has been rendered is in full accord with the Court of Appeals in this case. In Huron Valley Hospital, Inc. v. City of Pontiac, 466 F. Supp. 1301, 1312 (E.D. Mich. 1979), Judge Cornelia G. Kennedy, now serving on the Sixth Circuit,

Petitioner also alleges that the decision below will have widespread impact on a variety of matters which, upon analysis, are of only the most tangential relevance. (Pet. at 10-15). "Appropriateness reviews"[11] and Professional Standards Review Organizations[12] are unrelated matters which were neither presented to nor passed upon by the Court of Appeals and are not now before this Court. Neither are the so-called "learned profession" exemption,[13] the *Parker* v. *Brown* state action doctrine,[14] the interstate commerce requirement of the Sherman

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ruled that in enacting the Health Planning Act of 1974, Congress intended a "partial repeal of the antitrust laws." The court entered summary judgment for the defendants.

[11] Petitioner asserts that under the Eighth Circuit's decision, HSA "appropriateness reviews" can be used to shield all manner of private activity "—no matter how anticompetitive—which ostensibly serves the goals of this program." (Pet. at 11). Petitioner assumes that the Court of Appeals conferred a blanket immunity for any conduct which purports to be related to the Health Planning Act of 1974, but as described *infra,* no such immunity has been conferred. See Section III.C.

[12] Petitioner asserts that "the rationale utilized in this case could readily be used to support the contention that the PSRO legislation, like the [Health] Planning Act, creates a blanket exemption from antitrust. . . ." (Pet. at 11). As explained in Section III.C. *infra,* the Court of Appeals did not create a blanket exemption in this case. Moreover, any repeal of antitrust which may be implicit in the PSRO legislation must depend upon the language and legislative history of that law.

[13] Petitioner argues that the decision of the Eighth Circuit will impair the effect of this Court's treatment of "learned professions" in Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975), and National Soc'y of Professional Engineers v. United States, 435 U.S. 679 (1978). (Pet. at 13). The issue of "learned professions" was never before the courts below because there has never been a claim of such an exemption in this case.

[14] Petitioner contends that this Court has been in the process of narrowing the state action "exemption" of Parker v. Brown, 317 U.S. 341 (1943), and that the decision of the Eighth Circuit will undermine this effort. (Pet. at 13). Putting aside the question of whether *Parker* has been narrowed or simply refined by subsequent decisions, the Court of Appeals did not rule on the state action doctrine, pointing out

Act[15] or the McCarran-Ferguson Act.[16] Petitioner's attempts to paint the decision below as governing the broadest spectrum of antitrust and administrative law are without merit. The only issue presented is whether the Health Planning Act of 1974 impliedly repealed the antitrust laws with regard to the specific conduct challenged in this case.

II. The Health Planning Act of 1974 Is Irreconcilable With—"Repugnant" to—the Antitrust Laws in the Circumstances of this Case

The doctrine of implied repeal of the antitrust laws was judicially created to resolve conflicts between statutory systems and the antitrust laws. It has been called a "shorthand verbalization of common sense." *Cavanagh Communities Corp.* v. *New York Stock Exchange,* 422 F. Supp. 382, 385 (S.D.N.Y. 1976). The Court of Appeals held that, with regard to the conduct alleged in this case, the Health Planning Act of 1974

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explicitly that it was not involved in this case. (App. 8a). See also Section III.C. *infra.*

[15] Petitioner suggests that the decision below will undercut this Court's decisions on interstate commerce because even though an antitrust defendant may be engaged "in commerce," it may nonetheless prevail if it can prove repeal. (Pet. at 13-14). This is self-evident, and in no way detracts from the standards governing the commerce requirement. Interstate commerce and implied repeal are separate issues, and interstate commerce was not raised before the Court of Appeals.

For this reason, petitioner's suggestion that the decision below would "effectively undo" the ruling in Hospital Building Co. v. Trustees of Rex Hospital, 425 U.S. 738 (1976), is unsound. This Court's decision in *Rex Hospital* was confined to the issue of interstate commerce. 425 U.S. at 747 n.5. Moreover, petitioner's assertion that the conduct subsequently invalidated in *Rex Hospital* would have been "shielded" by the decision of the Court of Appeals in this case erroneously assumes that the Court below conferred "blanket" immunity, covering even such acts as the bad-faith tactics, frivolous litigation and malicious publicity alleged in *Rex Hospital.* As described hereafter, no such blanket immunity was conferred in this case. See Section III.C. *infra.*

[16] Although petitioner asserts that the decision of the Court of Appeals impairs the effect of this Court's decisions regarding the McCarran-Ferguson Act, 15 U.S.C. § 1012, the Eighth Circuit specifically held that the Act is not applicable to this case. (App. 15a). Although BCA does not agree, it is not seeking review of that determination in this Court.

impliedly repealed the antitrust laws because its encouragement of private participation in federal health care cost containment efforts is irreconcilable with antitrust and it was the intent of Congress that such conduct should not be subject to antitrust attack.

The antitrust laws, which condemn combinations or conspiracies in restraint of trade, are so antagonistic to the Health Planning Act's provisions for cooperative participation by private parties that the two are plainly repugnant to one another. The Court of Appeals determined that, in the context of this case, an irreconcilable conflict with antitrust is created by the Health Planning Act's specific provisions "for voluntary cooperation and assistance of private entities and persons in the community and health care market." (App. 7a). It held that if private entities cooperating with Health Systems Agencies "to achieve the goals of the Act were liable or might be liable under the antitrust laws for their action, then . . . the accomplishment of the purpose of the goals of the Act would be effectively foreclosed." (App. 8a).

The Blue Cross conduct here comes within the Act, which directs each HSA to implement its Health Systems Plan with the assistance of individuals and non-government entities.[17] 42 U.S.C. § 300*l*-2(c)(1); S. Rep. No. 93-1285, 93d Cong., 2d Sess., *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7888. The Act provides that "[s]ince the health care provider is one of the most important participants in any health care delivery system, . . . it is imperative that the provider be encouraged to play an active role in developing health policy at all levels." 42 U.S.C. § 300k(a)(5). The Act thus encourages entities such as Blue Cross to take actions consistent with the stated goals and purpose of the Act.

In creating the 1974 Act, Congress found that "the need for additional hospital beds in the nation has virtually dis-

[17] MAHSA also found the voluntary cooperation of parties such as Blue Cross important to the implementation of its Plan. (HSP 1978-1982 at 6-22).

appeared," S. Rep. No. 93-1285, 93d Cong., 2d Sess., *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7864, and that the growing surplus of hospital beds had become a critical national problem. *Id.* at 7878-7879; 42 U.S.C. § 300k(a)(4). MAHSA's studies confirmed that the Kansas City area in particular was suffering from a surplus of hospital beds. (HSP 1978-1982 at 6-19 and 7-3).

Consistent with these findings, the Blue Cross Plan Board of Trustees unilaterally adopted the following criteria in order to contract with hospitals on January 1, 1976:

> "The hospital must meet a clearly evident need for health care services in its defined service area. Health care institutions and institutional services shall be approved, and/or if required by law, certified as necessary, by the designated planning agency or area-wide health planning agency respectively; or, when effective, by the designated State Agency as provided for in Public Law 93-641, the 'National Health Planning and Resources Development Act of 1974.'"

(Petitioner's Court of Appeals Brief at 11). This policy does no more than incorporate national policy. Indeed, what else could Blue Cross have done — its only alternative was to flout the express objectives of the Health Planning Act of 1974. Petitioner's claim is that by doing exactly what was expected under the Act — by acting consistently with its underlying purpose and goals — Blue Cross could and did violate the antitrust laws. The clear repugnancy between the two statutory schemes is brought into sharp focus by nothing so well as this very claim.

The Court of Appeals properly concluded that Congress intended an implied repeal of the antitrust laws in the circumstances of this case:

> "The legislative history indicates to this Court that any attempts by companies such as these defendants to reduce costs and duplication were to be welcomed and were considered essential to a successful program of cost reduction." (App. 12a).

The Court of Appeals noted the Senate Committee Report accompanying the Health Planning Act of 1974, which found that there had been a failure in the health care industry to "respond to classic market place forces" (App. 11a), and that each Health Systems Agency would be directed by the Act "to seek to implement its long-range goal Plan and short-term priorities Plan with the assistance of individuals and public and private entities in its health area." (App. 13a).

The conclusion of the Court of Appeals was reinforced by the statement of Representative Paul Rogers, Chairman of the Subcommittee on Health and the Environment of the House Committee on Interstate and Foreign Commerce, in the debates concerning the 1979 amendments to the Health Planning Act. Representative Rogers clearly articulated the congressional intent to override antitrust in the case of cooperation by private entities:

> "Although Public Law 93-641 [the Health Planning Act of 1974] contains no specific exemption from the antitrust laws, an analysis of the activities required of HSA's and providers indicates that Congress sanctioned actions which might otherwise be in violation of our antitrust laws. The intent of Congress was that HSA's and providers who voluntarily work with them in carrying out the HSA's statutory mandate should not be subject to the antitrust laws. *If they were, Public Law 93-641 simply could not be implemented.* Congressional Record House, No. 18 Part 1, p. H11962-H11963." (App. 14a-15a) (emphasis added).[18]

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[18] In the Court of Appeals the Federation of American Hospitals (identified in note 2 *supra*) argued that Representative Rogers' remarks did not support the Court's conclusion because he assertedly was referring to immunity only for *hospitals* as "providers" and only in instances where there is state certificate of need legislation. (Federation of American Hospitals Brief at 20-21). When the remarks are read in full context, however, it becomes clear that Representative Rogers referred to hospitals only as an "example" of provider cooperation and referred to the interaction of the Health

The courts below were correct in concluding that the antitrust laws were intended to be impliedly repealed in the circumstances of this case. What Blue Cross is charged with doing is nothing more than what was intended by Congress.

III. Petitioner's Arguments Are Without Merit

A. The Health Planning Act of 1974 Is Premised Upon the Elimination of Competition for Inpatient Services

The fulcrum of petitioner's case is the principle that "the unrestrained interaction of competitive forces will yield the best allocation of our economic resources, the lowest prices, the highest quality and the greatest material progress." *Northern Pacific Railway Co.* v. *United States,* 356 U.S. 1, 4 (1958). (Pet. at 7-8). In fact, Congress found exactly the opposite: that the unrestrained interaction of competitive forces does *not* serve the public interest in the peculiar circumstances of inpatient hospital services and should *not* be encouraged because "the health care industry does not respond to classic marketplace forces." S. Rep. No. 93-1285, 93d Cong., 2d Sess., *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7878.[19] The conclusion of Congress was, essentially, that the last thing this country needs is competition in the form of building more hospital beds.[20] (See also Section IV *infra*).

Planning Act of 1974 and certificate of need legislation as only one indication of Congress' intent that there be an implied repeal.

[19] *Cf.* Latin America/Pacific Coast S.S. Conf. v. FMC, 465 F.2d 542, 546 (D.C. Cir. 1972) ("There are . . . particular economic or social objectives sought by Congress which are unattainable through the free forces of competition.")

[20] This conclusion was reaffirmed in recent congressional hearings where Charles Schultz, Chairman of the Council of Economic Advisors, remarked that the health care industry lacks most of the characteristics of a free market economy. He explained that "in the case of hospital costs, the buyer and seller are the same person" since most decisions are made by the physician.

> "Indeed, if this had been the major form that our industries had taken over the past 200 years, you would never have seen Adam Smith's 'Wealth of Nations' published because it would not make any sense." *Hearings on S. 570 Before the Subcomm. on*

B. The 1979 Amendments to the Health Planning Act of 1974 Preclude Competition For Inpatient Services

Petitioner maintains that Congress could not have intended to repeal the antitrust laws with the Health Planning Act of 1974 because the 1979 amendments to the Act indicate a congressional intention that "competition is to play a significant role in the delivery of health care services." (Pet. at 9). This is in error because such statements in the 1979 amendments pertain only to *outpatient* services, not to the *inpatient* services here.

The key to this case is that Congress has drawn a critical distinction between inpatient and outpatient care in formulating the Health Planning Act and its amendments.

It is correct that the intent of Congress in the 1974 Act was elucidated in the 1979 amendments, but not to the effect which petitioner suggests. In 1979 Congress explicitly *rejected* competition as an appropriate mechanism for allocating *inpatient* services, while recognizing that competition in *outpatient* services should be encouraged to the extent it is found to result in the appropriate allocation of such services. As petitioner points out, Congress called for "[t]he strengthening of competitive forces in the health services industry" (Pet. at 9), but this is only half the quotation. What Congress called for was "[t]he strengthening of competitive forces in the health services industry wherever competition and consumer choice can constructively serve, *in accordance with subsection (b) of this section,* to advance the purposes of quality assurance, cost effectiveness, and access." 42 U.S.C. § 300k-2(a)(17) (emphasis added).[21]

Health and Scientific Research of the Senate Comm. on Labor and Human Resources, 96th Cong., 1st Sess. 110 (1979).

A similar note was sounded by HEW Secretary Joseph Califano, Jr., who stated flatly that "the traditional competitive forces of the marketplace do not operate in the hospital industry." *Id.* at 72.

[21] See also 42 U.S.C. § 300*l*-2(a)(5), which calls for "preserving and improving, *in accordance with section 300k-2(b) of this title,* competition in the health service area." (Emphasis added).

National Gerimedical totally misapprehends subsection 300k-2(b) in the 1979 amendments, which, in its three paragraphs, makes clear that Congress was calling for competition only with regard to outpatient services, *not* with regard to inpatient hospital bed construction.

The first paragraph of subsection 300k-2(b) is a finding on the effects of competition:

> "(1) The Congress finds that the effect of competition on decisions of providers respecting the supply of health services and facilities is diminished. The primary source of the lessening of such effect is the prevailing methods of paying for health services by public and private health insurers, *particularly for inpatient health services* and other institutional health services. *As a result, there is duplication and excess supply of certain health services and facilities, particularly in the case of inpatient health services.*" 42 U.S.C. § 300k-2(b)(1) (emphasis added).

The second and third paragraphs of subsection 300k-2(b) distinguish between services where competition should *not* be encouraged, specifically including inpatient services, and services where competition should be encouraged:

"(2) For health services, *such as inpatient health services* and other institutional health services, *for which competition does not or will not appropriately allocate supply* consistent with health systems plans and State health plans, health systems agencies and State health planning and development agencies should in the exercise of their functions under this subchapter take actions (where appropriate to advance the purposes of quality assurance, cost effectiveness, and access and the other purposes of this subchapter) to allocate the supply of such services."

"(3) For the health services *for which competition appropriately allocates supply* consistent with health systems plans and State health plans, health systems agencies and State health planning and development agencies should in the performance of their functions under this subchapter give priority (where appropriate to advance the purposes of quality assurance, cost effectiveness, and access) to actions which would strengthen the effect of competition on the supply of such services."

42 U.S.C. § 300k-2(b)(2),(3) (emphasis added).

Thus, competition, the bedrock of the Sherman Act, has emerged under the Health Planning Act as the bete noire for inpatient services, which have become overabundant, and "for which competition does not or will not appropriately allocate supply."[22]

In a word, petitioner has pointed only to paragraph (b)(3), which is irrelevant (Pet. at 9), and has never mentioned paragraph (b)(2), which relates to the inpatient health services here.

C. The Court Below Did Not Grant A "Blanket Exemption"

Petitioner states over and over that the Court of Appeals improperly created a "blanket exemption" from the antitrust laws. (Pet. at 7, 8, 15, 16, 19, 22, 24; *cf.* 11, 12).[23] Nowhere does "blanket" appear in the Court of Appeals' opinion. On the contrary, the implied repeal was confined. The Court of Appeals held only that "the doctrine of implied immunity applies to Blue Cross' voluntary cooperation with the congressionally designated HSA in requiring [National Gerimedical] to obtain need approval from MAHSA prior to applying for a Blue Cross membership contract." (App. 15a). The Court rested its holding on

> "the specific provisions of the National Health Planning and Resources Development Act for voluntary cooperation

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[22] Petitioner cites a commentator (Pet. at 9) to the effect that it would be "anomalous" to interpret "a statute designed to make use of competition" in such a way as "to invalidate the means to enforce it." Miller, *Antitrust and Certificate of Need: Health Systems Agencies, The Plan Act, and Regulatory Capture,* 68 GEORGETOWN L.J. 873, 891 (1980). This commentator *recognizes* that subsection (b) serves to "exclude inpatient health services" from competition, but complains that so long as inpatient services are excluded, "the ability of planning agencies to strengthen competitive forces will be narrow in scope." *Id.* Having said this, the commentator criticizes the supposed anomaly, but it is misleading for petitioner to suggest that this view reflects the intent of Congress when the opposite is true.

[23] The district court did refer to a "blanket exemption." (App. 32a). Whether or not the district court actually applied such an exemption, however, is not the issue because the Court of Appeals never even mentioned "blanket" exemptions.

> and assistance of private entities and persons in the community and health care market. While the doctrine of implied immunity is to be used sparingly and only when necessary, *Gordon* v. *New York Stock Exchange, Inc.*, 422 U.S. 659 (1975), these provisions make the instant situation one well-suited for its use." (App. 7a).

Indeed, the Court of Appeals held that implied immunity arises only if there is "a clear repugnancy between the antitrust laws and the specific conduct at issue . . . ." (App. 7a). It relied upon this Court's opinion in *United States* v. *National Association of Securities Dealers,* 422 U.S. 694, 734 (1975), for the proposition that:

> "Implied immunity can be found in 'particular and discrete instances to assure that the federal agency entrusted with regulation in the public interest could carry out that responsibility free from the disruption of conflicting judgments that might be voiced by courts exercising jurisdiction under the antitrust laws.' " (App. 10a-11a).

Petitioner argues that implied immunity "must be narrowly limited to that which is actually required to make the federal regulatory scheme work" (Pet. at 23), but this is precisely the test which the Court of Appeals applied. Petitioner argues further that the Court below "went out of its way to find a conflict" (Pet. at 24), when in fact there was a finding that immunity was necessary to permit the Act to be implemented. (App. 7a, 15a). Indeed, there was no need for the Court of Appeals to find a "blanket exemption" in the particularly compelling factual circumstances of this case. Any statutory scheme, even one that does not create a total exemption from antitrust, can confer implied immunity from antitrust claims in particular instances, and this is all that the Court of Appeals held.[24]

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[24] Petitioner asserts the doctrine of "expressio unius est exclusio alterius" for the proposition that Congress intended immunity only for members or employees of an HSA, since this is specifically provided for in the Act. Petitioner's reliance on this doctrine is erroneous, however, because the inclusion of an express immunity provision in a statute does not preclude a finding of implied immunity. *See* United States v. National Ass'n of Securities Dealers, 422 U.S. 694, 720

D. Petitioner's Additional Arguments Are Invalid

Petitioner also argues that there should be no implied repeal because the Health Planning Act of 1974 assertedly involves "no federal regulatory scheme whatever" and because there purportedly was "no governmental oversight whatever." (Pet. at 16, 20). Neither of these arguments has any validity.

First, there *is* a regulatory scheme at work here. (See App. 9a-10a). Petitioner's contention is that because Missouri had no state certificate of need legislation in effect during the period when Blue Cross rejected its application, the Health Planning Act was serving no regulatory function in Missouri at that time. Between June 30, 1976 and the August, 1979 passage of Missouri's certificate of need legislation (effective October 1, 1980), Missouri had no need review mechanism,[25] but the fact that a state may not have enacted certificate of need legislation at a particular time does not detract from the applicability of the Health Planning Act of 1974 or from the duties of the HSA's operating in that state, including reduction of "documented inefficiencies" and implementation of a Health Systems Plan. 42 U.S.C. § 300*l*-2(a)(5). It does not mean that there would be "no federal regulatory scheme" in such a state, but only that there would not be *state* involvement in the scheme. MAHSA, the federally-designated HSA, was fulfilling its regu-

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(1975) (immunity inferred under § 22(f) despite inapplicability of express immunity in § 22(d) of Investment Company Act of 1940); Pan American World Airways, Inc. v. United States, 371 U.S. 296, 305-310, 320 (1963) (implied immunity applied to transactions that could not be immunized under express provision of § 414 of the Federal Aviation Act).

Petitioner also cites certain Business Review Clearances of the Department of Justice (Pet. at 10) which express the opinion that the Health Planning Act does not create "a complete antitrust exemption." Petitioner fails to note that these letters *granted* most of the clearances requested. Moreover, the language quoted referred to agreements "among competing hospitals" (Pet. at 28, 29-30), and is of no relevance to the conduct passed upon by the Court of Appeals.

[25] Prior to the 1974 Act, a moratorium on hospital construction already existed in the Kansas City area because of a surplus of beds. S. Rep. No. 93-1285, 93d Cong., 2d Sess., *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7852.

latory function at all relevant times and National Gerimedical cannot escape the provisions of the Act merely because the State of Missouri had hesitated in enacting its own legislation.

The Court of Appeals pointedly disposed of this argument, saying that National Gerimedical's "emphasis upon the fact that Missouri was not a participating state . . . misses the focus of the doctrine of implied immunity. The doctrine should not be confused with the state action exemption to the antitrust laws as articulated in *Parker* v. *Brown,* 317 U.S. 341 (1943)." (App. 8a, see also App. 9a).

Second, petitioner's argument that there was "no government oversight whatever" is equally defective—there was extensive government oversight. MAHSA, faithful to its federal mandate, made a reasoned determination, following an investigation and public hearings, that additional hospital beds were unwarranted in the Kansas City area. (HSP 1978-1982 at 7-3). Blue Cross lent its support to the achievement of MAHSA's goals.[26] Not only were MAHSA's investigation and plan required by the Health Planning Act of 1974, but every step of MAHSA's procedure was carried out pursuant to the detailed requirements of the Act.[27]

* * *

The holding that the antitrust laws have been impliedly repealed in the circumstances of this case has been unanimous. All three judges on the panel of the Court of Appeals agreed with the district judge. A petition for rehearing *en banc* was denied. The conclusion of every judge has been the same —Blue Cross' determination not to contract with petitioner does not violate the Sherman Act because the Health Planning Act of 1974 impliedly repeals its application in these circumstances.

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[26] Although petitioner complains that there was "no mechanism for administrative review" (Pet. at 21), it could have sought reconsideration of MAHSA's determination of hospital bed oversupply. *See* 42 U.S.C. § 300*l*-2(b)(2). In fact, petitioner never approached MAHSA at all.

[27] Specifically, MAHSA was required to assemble and analyze data concerning the status of health and health care in its area; the number, type and location of health care facilities; the patterns of utilization of these facilities; and the effect of the area's health care

IV. Petitioner Is Seeking to Undermine Congress' Purpose to Control Hospital Costs

At the heart of this case is the control of hospital costs. Pitted against each other are the national interest in arresting inflation attributable to hospital overbedding and the economic self-interest of a single hospital, in circumstances where Congress has recognized that the two cannot be reconciled. (See Sections III.A. and III.B. *supra*). Yet National Gerimedical, which is seeking to increase the cost of health care, accuses Blue Cross and MAHSA of conspiring to undermine the public interest. (Pet. at 8-9).

The goals of the Health Planning Act of 1974, reflected in the HSA's statutory purpose, are to restrain increases in hospital costs and eliminate "unnecessary duplication of health resources." 42 U.S.C. § 300*l*-2(a)(3), (4). In passing the 1974 Act, Congress cited evidence that by 1975, over 67,000 unneeded hospital beds would be in operation throughout the United States. S. Rep. No. 93-1285, 93d Cong., 2d Sess., *reprinted in* [1974] U.S. Code Cong. & Ad. News 7842, 7878-79. In enacting the 1979 amendments, Congress cited estimates indicating that by 1979 the oversupply of hospital beds had reached 130,000. S. Rep. No. 96-96, 96th Cong., 1st Sess. 8, *reprinted in* [1979] U.S. Code Cong. & Ad. News 1306, 1313. One hundred and twenty of those beds were placed by National Gerimedical.

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delivery system on the health of area residents. 42 U.S.C. § 300*l*-2(b)(1). In formulating its plan, MAHSA was required to consider the recommended national guidelines for health planning policy issued by the Secretary of Health and Human Resources, the priorities set forth in the Health Planning Act, and the data which it was required to assemble. Its plan was required to include a statement of goals describing the type of health care system sought to be achieved, and these goals were expected to be responsive to the needs and resources of the area and to take into account the national guidelines for health planning policy. 42 U.S.C. § 300*l*-2(b)(2). Before establishing its Health Systems Plan, MAHSA was required to conduct a public hearing and give interested persons an opportunity to submit their views orally and in writing. In addition, it was required to establish an annual implementation plan, subject to yearly review. *Id.* Moreover, all of the activities of MAHSA were subject to continuous review by the United States Department of Health and Human Services. 42 U.S.C. § 300*l*-4.

CONCLUSION

For the reasons described above, we respectfully request that the petition for a writ of certiorari be denied.

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Respectfully submitted,

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APPENDIX

STATUTORY PROVISIONS INCLUDED

Section 1 of the Sherman Act, 15 U.S.C. § 1, provides in pertinent part:

> "Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal. . . ."

Section 2 of the Sherman Act, 15 U.S.C. § 2, provides in pertinent part:

> "Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony. . . ."

The relevant provisions of the National Health Planning and Resources Development Act of 1974, 42 U.S.C. §§ 300k *et seq.* provide in pertinent part:

Section 300k(a):

> "The Congress makes the following findings:
>
> (1) The achievement of equal access to quality health care at a reasonable cost is a priority of the Federal Government.
>
> (2) The massive infusion of Federal funds into the existing health care system has contributed to inflationary increases in the cost of health care and failed to produce an adequate supply or distribution of health resources, and consequently has not made possible equal access for everyone to such resources.
>
> (3) The many and increasing responses to these problems by the public sector (Federal, State, and local)

and the private sector have not resulted in a comprehensive, rational approach to the present—

(A) lack of uniformly effective methods of delivering health care;

(B) maldistribution of health care facilities and manpower; and

(C) increasing cost of health care.

(4) Increases in the cost of health care, particularly of hospital stays, have been uncontrollable and inflationary, and there are presently inadequate incentives for the use of appropriate alternative levels of health care, and for the substitution of ambulatory and intermediate care for inpatient hospital care.

(5) Since the health care provider is one of the most important participants in any health care delivery system, health policy must address the legitimate needs and concerns of the provider if it is to achieve meaningful results; and, thus, it is imperative that the provider be encouraged to play an active role in developing health policy at all levels.

(6) Large segments of the public are lacking in basic knowledge regarding proper personal health care and methods for effective use of available health services."

Section 300k(b):

"In recognition of the magnitude of the problems described in subsection (a) of this section and the urgency placed on their solution, it is the purpose of this Act to facilitate the development of recomendations for a national health planning policy, to augment areawide and State planning for health services, manpower, and facilities, and to authorize financial assistance for the development of resources to further that policy."

Section 300k-2(a):

"The Congress finds that the following deserve priority consideration in the formulation of national health planning goals and in the development and operation of Federal, State, and area health planning and resources development programs:

* * *

(17) The strengthening of competitive forces in the health services industry wherever competition and consumer choice can constructively serve, in accordance with subsection (b) of this section, to advance the purposes of quality assurance, cost effectiveness, and access."

Section 300k-2(b):

"(1) The Congress finds that the effect of competition on decisions of providers respecting the supply of health services and facilities is diminished. The primary source of the lessening of such effect is the prevailing methods of paying for health services by public and private health insurers, particularly for inpatient health services and other institutional health services. As a result, there is duplication and excess supply of certain health services and facilities, particularly in the case of inpatient health services.

(2) For health services, such as inpatient health services and other institutional health services, for which competition does not or will not appropriately allocate supply consistent with health systems plans and State health plans, health systems agencies and State health planning and development agencies should in the exercise of their functions under this subchapter take actions (where appropriate to advance the purposes of quality assurance, cost effectiveness, and access and the other purposes of this subchapter) to allocate the supply of such services.

(3) For the health services for which competition appropriately allocates supply consistent with health sys-

tems plans and State health plans, health systems agencies and State health planning and development agencies should in the performance of their functions under this subchapter give priority (where appropriate to advance the purposes of quality assurance, cost effectiveness and access) to actions which would strengthen the effect of competition on the supply of such services."

Section 300*l*-1(b)(3)(C):

"The membership of the governing body and the executive committee (if any) of an agency shall meet the following requirements:

* * *

(ii) The remainder of the members shall be residents of, or have their principal place of business in, the health service area served by the agency who are providers of health care and who represent (I) physicians (particularly practicing physicians), dentists, nurses, optometrists, podiatrists, physician assistants, and other health professionals, (II) health care institutions (particularly hospitals, long-term care facilities, rehabilitation facilities, alcohol and drug abuse treatment facilities, and health maintenance organizations), (III) health care insurers, (IV) health professional schools, (V) the allied health professions, and (VI) other providers of health care. Not less than one-half of the providers of health care who are members of the governing body or executive committee of a health systems agency shall be direct providers of health care (as described in section 300n(3) of this title) and of such direct providers of health care, at least one shall be a person engaged in the administration of a hospital."

Section 300*l*-2(a):

"For the purpose of—

(1) improving the health of residents of a health service area,

(2) increasing the accessibility (including overcoming geographic, architectural, and transportation barriers), acceptability, continuity, and quality of the health services provided them,

(3) restraining increases in the cost of providing them health services,

(4) preventing unnecessary duplication of health resources, and

(5) preserving and improving, in accordance with section 300k-2(b) of this title, competition in the health service area, each health systems agency shall have as its primary responsibility the provision of effective health planning for its health service area and the promotion of the development within the area of health services, manpower, and facilities which meet identified needs, reduce documented inefficiencies, and implement the health plans of the agency."

Section 3007-2(c):

"A health systems agency shall implement its HSP and AIP, and in implementing the plans it shall perform at least the following functions:

(1) The agency shall seek, to the extent practicable, to implement its HSP and AIP with the assistance of individuals and public and private entities in its health service area."